

BEFORE THE ARIZONA MEDICAL BOARD

IN THE MATTER OF :

JOHN V. DOMMISSE, M.D.,

Holder of License No. 22164
For the Practice of Allopathic Medicine
In the State of Arizona

No. 03F-22164-MDX

Case Nos. MD-98-0006; MD-99-0096;
MD-99-0543

**AMENDED
FINDINGS OF FACT, CONCLUSIONS
OF LAW AND ORDER FOR DECREE OF
CENSURE AND PROBATION**

On September 10, 2003 this case came before the Arizona Medical Board ("Board") for oral argument and consideration of the Recommended Decision of the Administrative Law Judge ("ALJ") containing proposed findings of fact, conclusions of law and a recommended order. Foster Robberson and Nat Clarkson represented the Arizona Medical Board. Sheldon Lazarow represented John V. Dommisse, M.D. ("Respondent"). Christine Cassetta, Assistant Attorney General, provided legal advice to the Board. On September 15, 2003 the Board issued Findings of Fact, Conclusions of Law and an Order for a Decree of Censure and Probation ("2003 Order"). After the 2003 Order was administratively final Respondent exercised his rights to judicial review by filing an appeal in the Maricopa County Superior Court.

On September 28, 2005 the Superior Court issued an Order remanding the 2003 Order to the Board for further action. At its December 8, 2005 Board meeting the Board considered the Superior Court's remand order and issued the following Amended Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

1. The Arizona State Medical Board ("Board") is the duly constituted authority for licensing and regulating the practice of allopathic medicine in the State of Arizona.

2. The Respondent is the holder of License No. 22164 for the practice of allopathic medicine in the State of Arizona.
3. Respondent received his formal medical training at the University of Cape Town Medical School in South Africa, graduating in 1965.
4. Respondent completed a general practice residency in Bridgeport, Connecticut, in 1967, at Bridgeport General Hospital.
5. Respondent obtained Canadian board certification in psychiatry in 1976, after completion of a residency-training in adult, adolescent and geriatric psychiatry at the University of Toronto's Clarke Institute of Psychiatry.
6. Respondent holds medical licenses in South Africa, Ontario, Canada, Virginia, Connecticut and Arizona.
7. Following his residency in Toronto, Respondent became a faculty member at the University of Toronto and headed the Toronto Western Hospital Psychiatry Day Hospital Program.
8. In approximately 1978, Respondent relocated to Portsmouth, Virginia where he practiced psychiatry as the Director of Out Patient Services at the Maryview Community Mental Health Center attached to Maryview General Hospital.
9. After two years, Respondent entered private practice in Portsmouth, Virginia in psychiatry.
10. Respondent began practicing "nutritional and metabolic" medicine while in Virginia. He did not undertake any formal study or training in nutritional and metabolic medicine. Rather, he engaged in self-study primarily by locating and reviewing articles from various sources. His self-study on these topics took place from the mid-1970s to the present.

- 1 11. Over the period of time while he was practicing in Virginia, Respondent started
2 using nutritional and metabolic methods his psychiatric practice.
- 3 12. Over a period of time with self-study, Respondent's nutritional and metabolic
4 practice evolved from a purely psychiatric practice to a more general practice
5 treating other diseases.
- 6 13. Respondent relocated his medical practice from Virginia to Tucson, Arizona in
7 1994.
- 8 14. The present makeup of Respondent's Tucson practice is approximately 50%
9 metabolic medicine; 35% nutritional medicine; and 15% psychiatry. Respondent
10 sees no patients for psychiatric care only. Any psychiatric care he provides is for
11 patients also presenting with non-psychiatric complaints.

12 ***Complaints and Investigations***

- 13
- 14 15. In 1997, the Board, then known as the Arizona Board of Medical Examiners,
15 received a complaint against Respondent from patient D.W., a former patient of
16 his. As a result of that complaint, the Board initiated investigation No. 11203.
- 17 16. In December 1997, the Board received a complaint against Respondent from Dr.
18 Robert E. Lending, concerning patients H.K. and K.K., who were husband and
19 wife. That complaint resulted in investigation No. 11583.

20 ***Investigation No. 11583: Patients H.K. and K.K.***

- 21 17. In December 1997, the Board received a complaint against Respondent from Dr.
22 Robert E. Lending concerning patients H.K. and K.K., who were husband and
23 wife.
- 24 18. Dr. Lending wrote in his letter to the Board dated December 29, 1997: "In the
25 case of [K.K.] I believe that Dr. Dommissie has made some incorrect diagnoses,

1 done some testing that was not indicated and has worsened my patient's anxiety
2 disorder creating a gloom and doom situation with her nutritional and metabolic
3 management."

4 19. Patient K.K. came to Respondent in essence to optimize her already good health.
5 She was initially seen by Respondent on September 12, 1997, when she was 40
6 years old.

7 20. Respondent ordered blood tests for K.K., including thyroid function, potassium,
8 and tests related to candida overgrowth.

9 21. Although there were no symptoms to warrant it, Respondent subjected K.K. to
10 unnecessary thyroid hormone testing. Her TSH test was 2.06, which is a normal
11 result. Respondent ordered further unnecessary testing, raising the possibility that
12 K.K. was suffering from hypothyroidism and made a tentative diagnosis of
13 thyroiditis-autoimmune.

14 22. Respondent did not perform a physical examination of patient K.K.

15 23. Respondent also diagnosed K.K. as suffering from systemic candidiasis, an
16 infection from the fungal organism known as candida. A diagnosis of systemic
17 candidiasis cannot properly be made without physical examination of the patient,
18 which Respondent failed to do. There was no reasonable medical basis to make
19 a diagnosis of systemic candidiasis for this patient.

20 24. Respondent testified that the term "systemic candidiasis" used in his notes is used
21 differently by nutritional physicians than it is by conventional doctors and is meant
22 to convey that there is an overgrowth of candida, not that there is the major
23 problems of systemic candidiasis as it is usually known to allopathic physicians.
24
25

- 1 25. Respondent improperly used the term "systemic candidiasis" for billing purposes
2 because that was the only diagnostic code under the E/M codes that he could use
3 for his treatment.
- 4 26. Respondent additionally diagnosed K.K. as suffering from macrocytosis when K.K.
5 had a normal red blood cell index. Dr. Alan R. Gaby, M.D., testifying for
6 Respondent, stated that to make such a diagnosis with a normal red blood cell
7 index would fall below the standard of care.
- 8 27. Respondent's evaluation of K.K., including the failure to conduct a physical
9 examination and ordering unnecessary tests, and erroneous diagnoses were
10 below the acceptable standard of care for an allopathic physician.
- 11 28. Patient H.K. was a 50-year old male who initially saw Respondent on November 5,
12 1997. He came to Respondent to see if there was a natural way of treating his
13 hypertension.
- 14 29. Dr. Robert E. Lending, the primary care physician for H.K., wrote in a letter to the
15 Board: "In the case of Mr. [H.K.], I am much more concerned that not only did Dr.
16 Dommissse give him diagnoses such as diabetes and thyroid disease which are
17 absolutely untrue, he also prescribed Levoxyl 50 mcg. unnecessarily which could
18 have [been] dangerous and [had] adverse side effects especially in a patient with
19 hypertension on anti-hypertensive medications...In conclusion, I believe that this
20 physician placed Mr. [K] in an unsafe situation pertaining to unnecessary
21 prescribing of Levoxyl."
- 22 30. At the initial visit and thereafter, Respondent failed to take or record H.K.'s vital
23 signs, including his blood pressure. He also did not perform or make any record of
24 an appropriate physical exam.
25

- 1 31. At the time that H.K. saw Respondent, he was on Cardizem and Lotensin for blood
2 pressure control.
- 3 32. On November 24, 1997, which was H.K.'s second visit to Respondent,
4 Respondent prescribed Levoxyl, a thyroid hormone (T-4) commonly used for the
5 treatment of an underactive thyroid gland.
- 6 33. Respondent's justification for prescribing Levoxyl to H.K. was a slightly below
7 normal reading on a free T-4 test, but two other thyroid hormone tests, a Thyroid
8 Stimulating Hormone ("TSH") and free T-3 performed on the patient were normal.
- 9 34. The American Association of Clinical Endocrinologists ("AACE") Guidelines placed
10 into evidence by Respondent are authoritative and persuasive with respect to the
11 standard of practice for diagnosing and treating hyperthyroidism and
12 hypothyroidism.
- 13 35. With respect to those guidelines, Respondent acknowledged during his testimony
14 that he does not accept or follow those guidelines as a whole. Rather, he picks
15 and chooses portions of the guidelines that are compatible with his preferred
16 manner of medical practice.
- 17 36. The AACE Guidelines state, "Appropriate laboratory evaluation is critical to
18 establish the diagnosis and cause of hypothyroidism in the most cost-effective
19 way. The most valuable test is a sensitive measurement of TSH level. A TSH
20 assay should always be used as the primary test to establish the diagnosis of
21 primary hypothyroidism." This is one aspect of the guidelines rejected by
22 Respondent.
- 23 37. The AACE Guidelines also list "additional tests" that may be used to assist in
24 diagnosing hypothyroidism. Listed among those tests is the free T-4 estimate test,
25 which was used by Respondent on this patient and on others. However, the free

1 T-3 test, which is frequently used by Respondent, is not listed in the guidelines as
2 an acceptable additional test. Respondent also rejects the recommendation to not
3 routinely use the free T-3 test.

4 38. The thyroid hormone testing performed on patient H.K. was slightly inconsistent in
5 that the TSH, which is the best and most accepted measurement, was normal but
6 the free T-4 test was slightly below normal. The free T-3 test was also normal.

7 39. Based upon the results of the thyroid hormone testing, a physical examination and
8 possible re-testing were called for rather than immediately prescribing medication.

9 40. Thyroid hormone replacement therapy, such as Levoxyl, carries risks for the
10 patient. One risk is creating cardiac stress. As a patient with high blood pressure,
11 this was a reasonable concern for H.K.

12 41. Respondent listed diabetes mellitus without complications as a diagnosis for H.K.
13 The evidence of record supports a finding that H.K. did not have diabetes.

14 42. Respondent suggested, through his testimony, that he prescribed chromium to
15 H.K. for treatment of diabetes, which the patient did not have. Respondent
16 testified that "mild diabetes can often be cured with chromium." There is no
17 medical evidence in the record to support Respondent's statement that chromium
18 is an accepted cure for diabetes.

19 43. Respondent fell below the standard of care when he diagnosed H.K. with
20 macrocytosis based upon blood work the patient had by another physician prior to
21 coming to Respondent which showed that the patient had a normal red blood cell
22 index. Respondent made grossly incorrect evaluations of H.K., including incorrect
23 diagnoses, and the prescription of Levoxyl could have been detrimental to the
24 patient's health. Other prescriptions, such as chromium, were unnecessary and
25 harmed the patient at least because he paid for unnecessary therapy.

Investigation No. 12563: Patient C.E.

44. Patient C.E. was a 54 year old woman who came to Respondent to be treated for chronic fatigue.

45. C.E. had been referred to Respondent by her primary care physician, Dr. Lute.

46. C.E. had been previously diagnosed with hypothyroidism by Dr. Lute and was already on Levoxyl 125 at the time Respondent saw her. C.E. had been taking the thyroid hormone medication since age 12.

47. Respondent did not conduct a physical examination of or take vital signs from C.E. on September 11, 1998, her first visit, or anytime thereafter.

48. Notwithstanding the lack of physical examination, Respondent noted 18 diagnoses on September 11, 1998, including chronic fatigue/postviral syndrome, autoimmune thyroiditis, chronic hypotension, and systemic candidiasis.

49. Respondent's conduct in making a diagnosis of chronic fatigue syndrome without conducting a thorough physical examination fell below the standard of care.

50. Respondent fell below the standard of care when he diagnosed hypotension in C.E. without taking the patient's blood pressure.

51. The thyroid function tests on C.E. ordered by Respondent were normal. Her TSH value was 1.2. Nonetheless, Respondent found that her thyroid "is under-treated in the T-3 fraction," and prescribed an additional thyroid hormone medication, Cytomel, in addition to the Levoxyl that she had been taking.

52. It was inappropriate and unnecessary to prescribe Cytomel for this patient. The addition of Cytomel to the patient's existing regimen of Levoxyl put C.E. at greater risk for developing thyrotoxicosis, which carried the risks of cardiac problems and premature development of bone loss or osteoporosis.

1 53. Respondent used a combination of thyroid hormones, which was contrary to good
2 practice. The use of that combination fell below the standard of care.

3 54. Respondent ordered laboratory tests to measure C.E.'s level of copper.

4 55. An elevated level of copper raises the possibility that the patient is suffering from
5 Wilson's disease, a liver disease that can advance to choris and is potentially
6 fatal. There is no indication in the patient's chart that Respondent ever considered
7 the possibility that C.E. had Wilson's disease or took steps to rule out that this
8 patient was suffering from Wilson's disease. However, Wilson's disease is a rare
9 disease. Respondent credibly testified that he did not further investigate for the
10 disease because the patient was not under 40 years of age and she did not have
11 any of the symptoms of liver disease or neurologic disease or behavioral
12 abnormalities that would be expected in persons with Wilson's disease. Under
13 this scenario, there is insufficient evidence to establish that Respondent violated
14 the standard of care.

15 56. When she was charged a missed appointment fee C.E. became unhappy and did
16 not return to Respondent after her second visit.

17 ***Investigation No. 13026: Patient S.L.***

18 57. In 1999, the Board received a complaint against Respondent from patient S.L. and
19 initiated investigation No. 13026.

20 58. Patient S.L., who was then a 47 year-old woman, first saw Respondent in his
21 office on April 28, 1995. Although she was a psychologist with a Ph.D., S.L. was
22 working in an administrative position in physical therapy.

23 59. S.L.'s main problem was noted to be continuing fatigue with episodes of "heart
24 racing and breathing heavy."
25

- 1 60. Prior to seeing Respondent, S.L. was taking Levoxyl while under the care of
2 another physician. She was also being treated for ulcerative colitis and had been
3 recovering from a cholecystectomy.
- 4 61. Approximately 20 years prior to being seen by Respondent, S.L. was diagnosed
5 with hypothyroidism and was placed on thyroid treatment for a period of time. She
6 was off the thyroid treatment for many years.
- 7 62. S.L. underwent an extensive course of treatment with Respondent. S.L. saw
8 Respondent approximately 27 times over the course of approximately 41 months.
- 9 63. Respondent did not ever perform an appropriate physical examination on S.L. or
10 take her vital signs.
- 11 64. On April 28, 1995, Respondent listed 14 diagnoses for S.L., including thyroiditis,
12 autoimmune; chronic fatigue syndrome/postviral syndrome; chronic hypotension;
13 orthostatic hypotension; and sinusitis, chronic/intermittent.
- 14 65. It is a standard practice for allopathic physicians in Arizona to take a patient's
15 blood pressure at an office visit, particularly an initial visit, and before making a
16 diagnosis of hypotension.
- 17 66. It was below the applicable standard of care for Respondent to diagnose patient
18 S.L. as suffering from chronic hypotension and orthostatic hypotension without
19 ever taking her blood pressure.
- 20 67. Sinusitis, which was diagnosed by Respondent, is an infectious process in one or
21 several sinus cavities. A physical examination, including examining the nose,
22 throat and face, and perhaps imaging techniques, are required before diagnosing
23 sinusitis. Respondent fell below the standard of care for an allopathic physician by
24 failing to do any of those procedures when diagnosing sinusitis.
- 25

1 68. The U.S. Centers for Disease Control has promulgated a case definition for
2 chronic fatigue syndrome ("CFS"). Among other things, an allopathic physician is
3 to conduct a thorough physical examination of the patient before making a
4 diagnosis of CFS. Respondent fell below the standard of care for an allopathic
5 physician by diagnosing S.L. as suffering from CFS without performing a physical
6 examination.

7 69. Respondent treated S.L. for Vitamin C deficiency (scurvy), which was a
8 questionable diagnosis given his failure to conduct a physical examination and the
9 self report that the patient was a vegetarian. Vegetarians are unlikely to have a
10 Vitamin C deficiency because of their intake of fruits and vegetables.

11 70. Respondent improperly diagnosed S.L. as having systemic candidiasis. He claims
12 that the term is used differently by nutritional physicians as explained earlier.
13 Respondent's use of this term meant to convey that there is an overgrowth of
14 candida is improper and below the standard for an allopathic physician. His use of
15 the diagnostic code was also improper.

16 71. On May 11, 1995, Respondent concluded that S.L.'s thyroid was "under treated."
17 He added Armour Thyroid, twice daily, to her ongoing medication regimen of
18 Synthroid. Respondent was made aware of the fact that S.L. was taking various
19 herbal supplements including kelp. Kelp is an iodine producing substance that
20 may be harmful to patients with thyroid conditions. Notwithstanding Respondent's
21 opinion that the amount of the iodine in the kelp supplement was small, he should
22 have at least warned S.L. of the potential harmful effects of taking it with her
23 thyroid condition.

24 72. Armour Thyroid consists of desiccated animal thyroid and includes two thyroid
25 hormones, both T-3 and T-4.

1 73. Under a discussion of the treatment and management of clinical hypothyroidism,
2 the 94.AACE Guidelines, state, "In general, desiccated thyroid hormone,
3 combinations of thyroid hormones, or triiodothyronine should not be used as
4 replacement therapy." With patient S.L., Respondent not only used desiccated
5 thyroid hormone (Armour Thyroid) but he also used a combination of thyroid
6 hormones (Armour Thyroid and Synthroid), which is contrary to the
7 recommendations of the AACE Guidelines and the accepted standard of care.

8 74. A risk to patients where a physician prescribes inappropriate replacement of
9 thyroid hormones, such as is the case of S.L., is that a patient who was
10 hypothyrotic can become hyperthrotic. Excessive thyroid hormone levels put the
11 patient at increased risk for cardiovascular problems and bone density or
12 osteoporosis.

13 75. Physician caused hyperthyroidism is known as iatrogenic hyperthyroidism.

14 76. The record is clear that S.L. suffered from iatrogenic hyperthyroidism while being
15 treated by Respondent. Respondent's office note dated January 30, 1996,
16 reflects that he increased S.L.'s T-4 and T-3 intake. At her next visit on March 11,
17 1996, Respondent's office note reflects that she "does have a fine tremor." At the
18 next visit on March 28, 1996, Respondent noted that the patient's thyroid functions
19 were "real good", but he again increased her T-4 (Levoxyl). At her next visit on
20 May 16, 1996, S.L. was noted to be "rather thin" because she had lost 25 pounds.
21 It is not possible to track S.L.'s weight loss from office visit to office visit because
22 Respondent never took and recorded her weight at any time during the period that
23 he treated her. On May 16, 1996, S.L. was also noted to have a rapid pulse. On
24 June 4, 1996, Respondent recognized that he was over-replacing S.L.'s thyroid
25

1 hormones and he made a slight decrease in his prescription of Levoxyl, but
2 continued both medications.

3 77. Tremors, weight loss and rapid pulse, which are all symptoms noted in
4 Respondent's office notes for S.L. from March 1996 through May 1996, are
5 symptoms of hyperthyroidism.

6 78. Post-menopausal and peri-menopausal women are at particular risk for
7 osteoporosis from the over replacement of thyroid hormones. At age 47, S.L. was
8 within this at-risk group. Because Respondent admittedly attempted to maintain
9 S.L.'s thyroid hormones at a high level and because it is clear that he over
10 replaced her thyroid hormones on occasions, S.L. should have been closely
11 monitored for osteoporosis. Respondent never checked her for osteoporosis.

12 ***Altering Laboratory Reference Ranges***

13 79. Laboratory records routinely include "reference ranges" for various tests. A
14 reference range is provided by the laboratory so the physician will know whether a
15 particular test result is normal. A reference range is established based on criteria
16 and testing of controls by each laboratory and can vary according to the
17 laboratory.

18 80. Respondent routinely disregarded, and continues to disregard, the reference
19 ranges set by laboratories that he used. He routinely made handwritten notations
20 in his patient's charts changing the laboratories' reference ranges.

21 81. At times, Respondent's changes to laboratory reference ranges resulted in a
22 normal laboratory result being interpreted by him as an abnormal laboratory result.

23 82. Respondent would prescribe or recommend a medication or supplement on the
24 basis that the patient's blood test was "abnormal" when, in fact, the test was
25 "abnormal" only because he had changed the laboratory's reference range.

1 83. Respondent sold various minerals and supplements to his patients through his
2 medical office. He stood to profit from the sale of a product that was medically
3 unnecessary.

4 84. The record reflects inconsistency within Respondent's own practice of changing
5 laboratory reference ranges. For example, for patient S.L. and tests run from
6 Corning Clinical Laboratory on November 20, 1997, Respondent changed the
7 upper limit of the reference range for Potassium, RBC to 110. Six days later, for
8 the same patient, same laboratory and same test, he set a different range, noting
9 the upper limit the reference range at 120. For patients K.K. and H. K and
10 Corning Laboratory on October 2, 1997, Respondent changed the upper limit for
11 Potassium, RBC to 120. A few weeks later, on November 17, 1997, he changed
12 the upper level for the same laboratory and test to 110. A practice that results in
13 such transparent inconsistencies is not based on valid scientific methodology.

14 85. This practice by Respondent is a violation of the accepted standard of care for
15 allopathic physicians in Arizona. It is not based on accepted scientific or medical
16 principles. It has resulted in harm to patients, at least in that they have been
17 prescribed or recommended to take medications or supplements that were both
18 unnecessary and costly.

19 ***Respondent's Patient Brochures and CV***

20 86. It is not unusual for a nutritional and metabolic physician to have a patient
21 brochure.

22 87. Respondent has prepared patient brochures and his personal curriculum vitae that
23 he makes available to patients and others.

24 88. Respondent's patient brochures make false claims about the benefits of his
25 practice.

1 89. Respondent's patient brochure states that he has had a "100% success rate for
2 depression and panic disorder." The Board presented credible and reliable
3 evidence that there is no scientific justification for a claim by any physician to a
4 100% success rate for curing depression and panic disorder. Respondent
5 presented no credible evidence to refute this evidence. Respondent gave general
6 testimony that his patient brochure is based on his patient population, but he
7 never provided any supporting documentation. His claim to a 100% success rate
8 for patients suffering from depression and panic disorder is inaccurate and
9 misleading.

10 90. Respondent's patient brochure states that another benefit of his practice is "the
11 probable prevention of senile dementia of the Alzheimer's type" (emphasis added
12 in original). His brochure further claims, "None of Dr. Dommissie's hundreds of
13 older patients have developed this dreaded illness [Alzheimer's disease] while
14 under his long-term care in all the 24 years he has been in private practice in
15 Portsmouth, VA and Tucson. Since 1-in-15 elderly Americans has 'Alzheimer's,
16 the only conclusion one can draw is that his nutritional-metabolic approach
17 prevents senile dementia of the Alzheimer's type" (emphasis in the original).

18 91. The Board presented credible testimony, through Dr. Kirschner, that there is no
19 methodology presently known to medical science to prevent Alzheimer's disease.
20 Respondent presented no competent evidence to the contrary. Respondent
21 acknowledged that he does not generally follow his former patients, such as those
22 from his Virginia practice. Therefore, he had no scientific or medical data for such
23 patients to support his claim. Respondent's statement that "his nutritional-
24 metabolic approach prevents senile dementia of the Alzheimer's type" is found to
25 be misleading and inaccurate.

1 92. Respondent's brochure also claims a two to four times greater success rate in
2 "beating" chronic fatigue than for standard medical practices. His brochure claims
3 that he is six to twelve times more successful "curing" chronic fatigue syndrome
4 than reflected in the standard medical literature. The Board presented credible
5 evidence that there are no medically valid reasons to accept Respondent's claims
6 to these astoundingly higher rates of success treating these conditions.
7 Respondent presented no credible evidence in support of his claims. Such
8 representations are inaccurate and misleading.

9 93. In his curriculum vitae, dated December 10, 1997, Respondent claimed a 100%
10 success rate for treating hypothyroidism. Given that one of his patients, S.L., was
11 clearly not successfully treated for this condition by Respondent, this claim is false
12 and misleading.

13 **CODING ISSUES**

14 94. Current Procedural Terminology ("CPT") is a list of descriptive terms and codes
15 promulgated by the American Medical Association ("AMA") to assist physicians in
16 reporting medical procedures and services. The CPT Codes are published by the
17 AMA.

18 95. CPT Code 99205 is defined as follows:

19 **Office or other outpatient visit** for the evaluation and management
20 of a new patient, which requires these three key components:

- 21 • **A comprehensive history;**
- 22 • **A comprehensive examination ; and**
- 23 • **Medical decision making of high complexity.**
(emphasis in original).

24 96. CPT Code 99244 is defined as follows:
25

1 **Office consultation** for a new or established patient, which requires
2 these three key components:

- 3 • **A comprehensive history;**
- 4 • **A comprehensive examination; and**
- 5 • **Medical decision making of moderate complexity.**
6 (emphasis in original).

7 97. Respondent has billed using CPT Codes 99205 and 99244.

8 98. Respondent's general approach to diagnosing and treating patients has been to
9 take a detailed history, order appropriate blood tests, and after making his
10 diagnoses, treating the patients with indicated prescriptions and/or nutritional
11 methods.

12 99. In his initial consultation with the patient, Respondent takes a 35 to 40 minute
13 history, or more, including an extensive personal history, medication, food and
14 drug history, and lifestyle history that includes smoking, drugs, caffeine, and diet.
15 He then takes a detailed systemic review history asking certain focus questions of
16 symptoms that they may have that are related to the original presenting
17 symptoms.

18 100. Respondent then spends 10 to 15 minutes of the remainder of the initial visit
19 deciding which specific blood tests to order.

20 101. Respondent does not perform full physical examinations in his practice.

21 102. At the time of the cases in this matter, Respondent did little if any focused physical
22 examinations; however, he now does full focused exams on all patients he
23 decides need such exams.

24 103. Respondent did not perform comprehensive examinations on the subject patients
25 or in his medical practice as the term is used in CPT Codes 99205 and 99244.

1 104. Respondent claims that he received permission from Medicare to use CPT Codes
2 99205 and 99244, despite his admission that he does not perform comprehensive
3 physical examinations. The Board investigated this claim and found it to be
4 unsubstantiated. Respondent was unable to present any credible evidence to
5 support his claim to an approved variance.

6 105. Respondent's improper use of CPT Codes is a recurring problem. One reason
7 underlying the Stipulation and Order was his misuse of CPT Codes. Respondent
8 admitted to the coding errors in D.W.'s case when he knowingly and voluntarily
9 entered into the Stipulation and Order.

10 106. Notwithstanding the above finding, Respondent's behavior and demeanor before
11 this tribunal was courteous, respectful and professional.

12 ***Miscellaneous***

13 107. Dr. Gaby's testimony characterized Respondent as a doctor of "natural medicine."

14 108. Another physician testifying for Respondent, Dr. Mark Bessette, testified that
15 Respondent's practice is different from an allopathic practice. Dr. Bessette is a
16 physician practicing in Tucson who refers patients to Respondent. Dr. Bessette
17 categorizes Respondent's practice as a "cross-over" between allopathic and
18 naturopathic medicine.

19 **CONCLUSIONS OF LAW**

20 1. The Board has jurisdiction over the subject matter and the Respondent pursuant
21 to A.R.S. § 32-1401 et seq.

22 2. The conduct and circumstances described in the above Findings of Fact constitute
23 unprofessional conduct by Respondent pursuant to A.R.S. § 32-1401(24)(e)
24 (Failing or refusing to maintain adequate records on a patient).
25

3. The conduct and circumstances described in the above Findings of Fact constitute unprofessional conduct by Respondent pursuant to A.R.S. § 32-1401(24)(m) (Representing that a manifestly incurable disease or infirmity can be permanently cured, or that any disease, ailment or infirmity can be cured by a secret method, procedure, treatment, medicine or device, if such is not the fact).
4. The conduct and circumstances described in the above Findings of Fact constitute unprofessional conduct by Respondent pursuant to A.R.S. § 32-1401(24)(q) (Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public).
5. The conduct and circumstances described in the above Findings of Fact constitute unprofessional conduct by Respondent pursuant to A.R.S. § 32-1401(24)(u) (Charging a fee for services not rendered).
6. The conduct and circumstances described in the above Findings of Fact constitute unprofessional conduct by Respondent pursuant to A.R.S. § 32-1401(24)(ll) (Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient).
7. Pursuant to A.R.S. § 32-1451(N), Respondent should be assessed the costs of the formal hearing in this matter.

ORDER

1. In view of the foregoing, it is ordered Respondent is issued a Decree of Censure for the unprofessional conduct described above and Respondent is placed on probation for a period of five years, subject to the terms and conditions enumerated below.


- a) Respondent shall comply with the Continuing Medical Education ("CME") requirements of the Stipulation and Order no later than 180 days from the effective date of the Order in this matter.
- b) Respondent shall within 180 days of the effective date of this Order, obtain 20 hours of Board Staff pre-approved Category I CME in diagnosis and treatment of thyroid disorders and provide Board Staff with satisfactory proof of attendance. The CME hours are in addition to the hours required for biennial renewal of medical license.
- c) Respondent shall practice nutritional and metabolic medicine within the standards of care for allopathic physicians in the State of Arizona.
- d) Not less than two times per year Respondent shall be subjected to chart review by Board staff.
- e) Respondent shall pay the costs of the administrative hearing. Board staff shall notify Respondent of the amount due. Respondent shall pay the costs within one year of receiving the notification of the amount due.
- f) Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all conditions of probation. The declarations must be submitted on or before the 15th day of March, June, September and December of each year.
- g) Respondent shall revise his patient brochure, including internet website, if any, and curriculum vitae by deleting the claims contained therein as noted in the above-provided Findings of Fact. Those documents shall only contain claims that can be supported by credible and reliable scientific and/or medical data.

- 1 h) Respondent shall obey all federal, state and local laws, and all rules
2 governing the practice of allopathic medicine in the State of Arizona.
- 3 i) In the event Respondent should leave Arizona to reside or to practice
4 medicine outside Arizona or for any reason should he stop practicing
5 medicine in this state, Respondent shall notify the Board's Executive
6 Director in writing within 10 calendar days of departure and return or the
7 dates of non-practice in Arizona. Non-practice is any period of time
8 exceeding 30 days during which Respondent is not engaging in the practice
9 of medicine. Periods of temporary or permanent residence or practice
10 outside of Arizona or of non-practice within Arizona do not apply to the
11 reduction of the probationary period.
- 12 j) Respondent shall pay the costs of compliance and monitoring his probation
13 as designated by the Board each and every year of probation. Such costs
14 may be adjusted on an annual basis. Costs to be paid to the Board are
15 payable no later than 60 days after invoice is sent to Respondent and
16 thereafter on an annual basis. Failure to pay these costs within 30 days of
17 the due date constitutes a violation of probation.
- 18 k) Respondent shall, at his own expense, undergo an evaluation within 120
19 days by the Physician Assessment and Clinical Education Program (PACE)
20 at the University of California, San Diego or at a Board Staff approved
21 program at the University of Arizona. Respondent shall comply with any
22 recommendations made by the evaluating entity.
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Done this 17th day of January, 2006.



By: 
Timothy C. Miller, J.D.
Executive Director

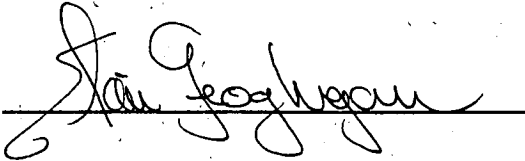
Arizona Medical Board
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Scottsdale, Arizona- 85258

Cliff J. Vanell, Director
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1400 West Washington, Suite 101
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Sheldon Lazarow
25 East University
Tucson, Arizona 85705-7736

John V. Dommissse, M.D.
Address of Record

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2 Assistant Attorney General
3 Office of the Attorney General
4 CIV/LES
5 1275 West Washington
6 Phoenix, Arizona 85007

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